

		FOR OHF USE					

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**2001**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2001)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0037473</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>FRIENDSHIP HOUSE OF CENTRALIA</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>MAY 1, 2000</u> to <u>APRIL 30, 2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>100 MARTIN LUTHER KING DRIVE</u> <u>CENTRALIA</u> <u>62801</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>MARION</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ <u>October 31, 2001</u> (Type or Print Name) <u>Douglas K. Mittleider</u> (Date)	
<b>Telephone Number:</b> <u>618-532-3642</u> <b>Fax #</b> <u>618-533-3739</u>		(Title) <u>President HP/Management , Inc. - Facility Management Co.</u>	
<b>IDPA ID Number:</b> <u>43158853505</u>		(Signed) _____ (Date)	
<b>Date of Initial License for Current Owners:</b> <u>2/12/92</u>		<b>Paid Preparer</b> (Print Name and Title) <u>Kathy Herman</u> <u>Senior Reimbursement analyst</u>	
<b>Type of Ownership:</b>		(Firm Name & Address) <u>HP / Management Group, Inc.</u> <u>950 North Pointe Pwky, Suite 100 Alpharetta, GA 30005</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		(Telephone) <u>770-619-0866 ext. 253</u> <b>Fax #</b> <u>770-619-0262</u>	
<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>GOVERNMENTAL</b> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>K. Herman HP/Mangt Co.</u> <b>Telephone Number:</b> <u>770-619-0866 ext. 253</u>			

Facility Name & ID Number FRIENDSHIP HOUSE OF CENTRALIA# 0037473 Report Period Beginning: MAY 1, 2000 Ending: APRIL 30, 2001

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>19</u>	Skilled (SNF)	<u>19</u>	<u>6,935</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>75</u>	Intermediate (ICF)	<u>75</u>	<u>27,375</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>94</u>	TOTALS	<u>94</u>	<u>34,310</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,335</u>	<u>136</u>	<u>2,827</u>	<u>4,298</u>	8
9	SNF/PED					9
10	ICF	<u>19,962</u>	<u>1,707</u>	<u>24</u>	<u>21,693</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,297</u>	<u>1,843</u>	<u>2,851</u>	<u>25,991</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 75.75%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)Meals = Guests/Emp

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/05/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/05/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 19 and days of care provided 2,827Medicare Intermediary MUTUAL OF OMAHA

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: APRIL 30 Fiscal Year: APRIL 30

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number FRIENDSHIP HOUSE OF CENTRALIA # 0037473 Report Period Beginning: MAY 1, 2000 Ending: APRIL 30, 2001

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	104,882	5,369	6,630	116,881	(120)	116,761		116,761		1
2	Food Purchase		128,003		128,003	(1,416)	126,587	(1,277)	125,310		2
3	Housekeeping	66,018	6,077		72,095		72,095		72,095		3
4	Laundry	37,934	4,841		42,775		42,775		42,775		4
5	Heat and Other Utilities			78,627	78,627		78,627	(27)	78,600		5
6	Maintenance	20,834	2,108	15,381	38,323	(4,515)	33,808		33,808		6
7	Other (specify):* Waste Disposal					4,455	4,455		4,455		7
8	<b>TOTAL General Services</b>	229,668	146,398	100,638	476,704	(1,596)	475,108	(1,304)	473,804		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,875	3,875	(1,250)	2,625		2,625		9
10	Nursing and Medical Records	790,097	28,501	2,225	820,823	10,580	831,403		831,403		10
10a	Therapy	15,683	20,194	127,925	163,802	(15,683)	148,119		148,119		10a
11	Activities	27,303	4,910	1,277	33,490		33,490		33,490		11
12	Social Services	28,291	440	1,212	29,943		29,943		29,943		12
13	Nurse Aide Training					19,350	19,350		19,350		13
14	Program Transportation			125	125	165	290	(290)			14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	861,374	54,045	136,639	1,052,058	13,162	1,065,220	(290)	1,064,930		16
	<b>C. General Administration</b>										
17	Administrative	49,657			49,657	6,013	55,670		55,670		17
18	Directors Fees										18
19	Professional Services			145,591	145,591	13,318	158,909		158,909		19
20	Dues, Fees, Subscriptions & Promotions			5,370	5,370	3,187	8,557	(1,545)	7,012		20
21	Clerical & General Office Expenses	34,075	6,654	45,751	86,480	(27,012)	59,468	6,861	66,329		21
22	Employee Benefits & Payroll Taxes			162,366	162,366	6,464	168,830		168,830		22
23	Inservice Training & Education			15,637	15,637	(14,997)	640		640		23
24	Travel and Seminar			9,292	9,292	(45)	9,247	(5,356)	3,891		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			44,393	44,393		44,393		44,393		26
27	Other (specify):* Misc. Expense			90	90	(90)					27
28	<b>TOTAL General Administration</b>	83,732	6,654	428,490	518,876	(13,162)	505,714	(40)	505,674		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,174,774	207,097	665,767	2,047,638	(1,596)	2,046,042	(1,634)	2,044,408		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name & ID Number **FRIENDSHIP HOUSE OF CENTRALIA**

#0037473

Report Period Beginning: **MAY 1, 2000** Ending:**APRIL 30, 2001**

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			141,774	141,774		141,774		141,774			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			298,488	298,488		298,488	(16,582)	281,906			32
33	Real Estate Taxes			5,480	5,480		5,480		5,480			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,339	3,339	180	3,519		3,519			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			449,081	449,081	180	449,261	(16,582)	432,679			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		92,404	2,370	94,774		94,774		94,774			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops					1,416	1,416	(1,416)				41
42	Provider Participation Fee			49,991	49,991		49,991		49,991			42
43	Other (specify):* <b>Xray &amp; Lab</b>			1,880	1,880		1,880		1,880			43
44	<b>TOTAL Special Cost Centers</b>		92,404	54,241	146,645	1,416	148,061	(1,416)	146,645			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,174,774	299,501	1,169,089	2,643,364		2,643,364	(19,632)	2,623,732			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **FRIENDSHIP HOUSE OF CENTRALIA**# **0037473**

Report Period Beginning:

**MAY 1, 2000**

Ending:

**APRIL 30, 2001****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	<b>NON-ALLOWABLE EXPENSES</b>	<b>1 Amount</b>	<b>2 Refer- ence</b>	<b>3 OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,233)	2		4
5	Telephone, TV & Radio in Resident Rooms	(27)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(16,582)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(733)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,013)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (19,632)		\$	30

<b>OHF USE ONLY</b>						
48		49	50	51	52	

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		<b>1 Amount</b>	<b>2 Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (19,632)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		<b>1 Yes</b>	<b>2 No</b>	<b>3 Amount</b>	<b>4 Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops	X		1,416	2	40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 1,416		47

STATE OF ILLINOIS  
FRIENDSHIP HOUSE OF CENTRALIA

Page 5A

ID# 0037473  
Report Period Beginning: MAY 1, 2000  
Ending: APRIL 30, 2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Resident Transportation - Cab Fare etc	\$ (290)	14	1
2	Prior Year Revenue Adjustment	17,102	21	2
3	Off Set Concession Revenue	(1,416)	41	3
4	Out of State Travel Entertainment Expenses	(5,356)	24	4
5	Chamber of Commerce Dues	(812)	20	5
6	Bank Charges - NSF Checks	(10,241)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,013)		49

## STATE OF ILLINOIS

## Summary A

Facility Name &amp; ID Number FRIENDSHIP HOUSE OF CENTRALIA

# 0037473

Report Period Beginning:

MAY 1, 2000

Ending:

APRIL 30, 2001

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,277)	0	0	0	0	0	0	0	0	0	0	(1,277)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(27)	0	0	0	0	0	0	0	0	0	0	(27)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,304)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,304)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(290)	0	0	0	0	0	0	0	0	0	0	(290)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(290)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(290)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,545)	0	0	0	0	0	0	0	0	0	0	(1,545)	20
21	Clerical & General Office Expenses	6,861	0	0	0	0	0	0	0	0	0	0	6,861	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,356)	0	0	0	0	0	0	0	0	0	0	(5,356)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(40)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(40)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(1,634)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,634)</b>	<b>29</b>





**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LISTING FOR HUNTER CARE CENTERS						

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

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Facility Name & ID Number **FRIENDSHIP HOUSE OF CENTRALIA** # **0037473** Report Period Beginning: **MAY 1, 2000** Ending: **APRIL 30, 2001**

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FRIENDSHIP HOUSE OF CENTRALIA # 0037473 Report Period Beginning: MAY 1, 2000 Ending: 2IL 30, 2001

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Prudential Huntoon Paige		x	First Mortgage	\$27,518.00		\$ 3,000,000	\$ 2,626,346	10-01-2039	0.0925	\$ 255,365	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	DVI	X		Working Capital	N/A	04/30/99	303,157	58,308	05/03/01	Floating	38,217	6	
7	HP Insurance	X		Liability/WC Insurance	N/A						4,906	7	
8												8	
9	TOTAL Facility Related					\$27,518.00		\$ 3,303,157	\$ 2,684,654			\$ 298,488	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related							\$	\$			\$	14
15	TOTALS (line 9+line14)							\$ 3,303,157	\$ 2,684,654			\$ 298,488	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **FRIENDSHIP HOUSE OF CENTRALIA**# **0037473** Report Period Beginning: **MAY 1, 2000** Ending: **APRIL 30, 2001****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2000 report.			\$ 32,353	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ 32,353	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 5,480	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 5,480	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1996	14,646	8	
	1997	15,655	9	
	1998	15,393	10	
	1999	16,960	11	
	2000	16,439	12	
<b>Accrued 4 months of Property Taxes</b>				
<b>16,439/12=1,369.92 x 4 = 5,480</b>				

<b>FOR OHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2000	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME FRIENDSHIP HOUSE OF CENTRALIA COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0037473

CONTACT PERSON REGARDING THIS REPORT Steve Henson - Tax Manager

TELEPHONE 770-619-0866 FAX #: 770-619-0262

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-17-000-059</u>	<u>Land and Buildings</u>	\$ <u>16,151.66</u>	\$ <u>16,151.66</u>
2. <u>14-17-100-005</u>	<u>Land</u>	\$ <u>129.92</u>	\$ <u>129.92</u>
3. <u>14-17-000-068</u>	<u>Land</u>	\$ <u>22.82</u>	\$ <u>22.82</u>
4. <u>14-17-000-056</u>	<u>Land</u>	\$ <u>134.12</u>	\$ <u>134.12</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>16,438.52</u></u>	\$ <u><u>16,438.52</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A.

Square Feet:

23,100

B. General Construction Type:

Exterior

BRICK & BLOCK

Frame

MASONARY

Number of Stories

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2	FACILITY GROUNDS	174,240	1996	60,000	2
3	TOTALS	174,240		\$ 60,000	3

Facility Name &amp; ID Number FRIENDSHIP HOUSE OF CENTRALIA

# 0037473

Report Period Beginning:

MAY 1, 2000 Ending: APRIL 30, 2001

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	94		1991	1965	\$ 3,154,267	\$ 74,193	40	\$ 74,193	\$ (0)	\$ 682,095	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		DOOR ALARM SYSTEM		1993	3,719	233	15	233		1,804	9
10		ROAD GRADING AND FILLING		1994	1,434	135	10	135	0	1,042	10
11		CENTRAL AC REPAIRS		1998	948	297	3	297	(0)	521	11
12		LANDSCAPING		1994	2,376		5			2,376	12
13		ALZHEIMER UNIT REMODELING		1996	197,692	18,600	10	18,600	(0)	86,145	13
14		REWORK SPRINKLER SYSTEM		1997	10,118	952	10	952	0	4,283	14
15		PIPING EXP. TANK		1997	5,708	767	7	767	(0)	3,349	15
16		SECURITY SYTEM		1997	2,355	443	5	443	(0)	1,915	16
17		Accu, Depreciation adjusted to B/S 1999-2000		2000						301	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ 1	\$ 1	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,378,617	\$ 95,621		\$ 95,621	\$ 0	\$ 783,832	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 488,009	\$ 45,915	\$ 45,915		10	\$ 312,793	71
72	Current Year Purchases	2,228	238	238	(0)	5	238	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 490,238	\$ 46,153	\$ 46,153	\$ (0)		\$ 313,031	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$			\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$			\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,928,855	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 141,774	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 141,774	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,096,863	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ 3,519

Description: See Attached Listing

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ \_\_\_\_\_

13. /2003 \$ \_\_\_\_\_

14. /2004 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input checked="" type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE <u>108</u>	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input checked="" type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE <u>75.5</u>
---	---	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	
2	Books and Supplies		2,910		2,910
3	Classroom Wages (a)		9,087		9,087
4	Clinical Wages (b)		6,352		6,352
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		1,001		1,001
9	TOTALS	\$	\$ 19,350	\$	\$ 19,350
10	SUM OF line 9, col. 1 and 2 (e)	\$ 19,350			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ N/A

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	22
2. From other facilities (f)	32
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	54

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					1	Licensed Occupational Therapist	10A-3	hrs	\$	
2	Licensed Speech and Language Development Therapist	10A-3	hrs		296	16,607		296	16,607	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		1,013	55,850		1,013	55,850	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify): LAB & XRAY	43-3				1,880			1,880	13
14	TOTAL			\$	2,361	\$ 129,805	\$	2,361	\$ 129,805	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (152,583)	\$	1
2	Cash-Patient Deposits	1,954		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	854,663		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	122,324		5
6	Prepaid Insurance	23,806		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 850,164	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	60,000		13
14	Buildings, at Historical Cost	3,154,267		14
15	Leasehold Improvements, at Historical Cost	224,350		15
16	Equipment, at Historical Cost	490,237		16
17	Accumulated Depreciation (book methods)	(1,096,863)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,831,991	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,682,155	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 3,479,388	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,954		28
29	Short-Term Notes Payable	58,308		29
30	Accrued Salaries Payable	68,290		30
31	Accrued Taxes Payable (excluding real estate taxes)	51,626		31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,480		32
33	Accrued Interest Payable	255,365		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>ACCURED BED TAX</u>	(8,686)		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 3,911,725	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	(144,629)		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ (144,629)	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,767,096	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (84,941)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,682,155	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ (598,326)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjust PY Balances from Hunter Net Income</b>	<b>598,326</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(84,935)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	<b>(6)</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (84,941)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (84,941)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1		Amount	
<b>Revenue</b>			
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,569,142	1
2	Discounts and Allowances for all Levels	(100,498)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,468,644	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	70,527	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 70,527	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,416	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,233	14
15	Telephone, Television and Radio	27	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,676	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	16,582	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 16,582	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,558,429	30

2		Amount	
<b>Expenses</b>			
<b>A. Operating Expenses</b>			
31	General Services	476,704	31
32	Health Care	1,052,058	32
33	General Administration	518,876	33
<b>B. Capital Expense</b>			
34	Ownership	449,081	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	96,654	35
36	Provider Participation Fee	49,991	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,643,364	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(84,935)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (84,935)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name & ID Number **FRIENDSHIP HOUSE OF CENTRALIA**# **0037473**Report Period Beginning: **MAY 1, 2000**

Ending:

**APRIL 30, 2001****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,253	2,395	\$ 45,965	\$ 19.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,548	3,603	59,239	16.44	3
4	Licensed Practical Nurses	16,470	16,725	200,996	12.02	4
5	Nurse Aides & Orderlies	59,271	60,341	461,916	7.66	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,533	3,650	27,303	7.48	10
11	Social Service Workers	3,021	3,279	28,291	8.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,303	15,428	104,882	6.80	15
16	Dishwashers					16
17	Maintenance Workers	23,193	2,480	20,834	8.40	17
18	Housekeepers	9,923	10,691	66,018	6.18	18
19	Laundry	6,080	6,478	37,934	5.86	19
20	Administrator	2,080	2,080	49,657	23.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,874	4,052	34,075	8.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,258	2,351	37,664	16.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	149,807	133,553	\$ 1,174,774 *	\$ 8.80	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	172	\$ 6,510	1-3	35
36	Medical Director		2,625	9-3	36
37	Medical Records Consultant	38	1,435	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,370	39-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,277	11-3	44
45	Social Service Consultant	26	1,212	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	264	\$ 15,429		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description	Amount		
Floyd Wreath	Administrator	0	\$ 44,323	Workers' Compensation Insurance		\$ 42,988	IDPH License Fee	\$ 400		
Kathy Berck	Administrator	0	11,347	Unemployment Compensation Insurance			Advertising: Employee Recruitment	47		
				FICA Taxes			Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance		9,329	Promotional Advertising/Community	733		
				Employee Meals			Chamber of Commerce Dues	812		
Wages Reclassed from Clerical			(11,347)	Illinois Municipal Retirement Fund (IMRF)*			Illinois Health Care Asso Dues	3,584		
Benefits Reclassed from HP Management			5,334	All Payroll Taxes		108,569	Professional Publications	750		
				Employee Physicals		2,500	Administrative Fees	2,231		
				Employee Incentive		110				

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
(See instructions.)

[illegible]

Facility Name & ID Number **FRIENDSHIP HOUSE OF CENTRALIA**

STATE OF ILLINOIS

# **0037473**

Report Period Beginning: **MAY 1, 2000** Ending: **APRIL 30, 2001**

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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL HEALTH CARE ASSOC 3,584
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? n/a
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 520 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 49,991  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? GUEST MEAL Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? YES  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? \_\_\_\_\_  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.